PEGASUS
PAIN MANAGEMENT

Accident Information

Patient information:

Patient Name:_____ Date: ____/____/_____

Make/Model of the vehicle you were in: _____

Make/Model of the other vehicle you collided with: _____

*Date of accident: ____/____/_____

Please describe the accident in your own words:

_____

_____

*Were you wearing a seatbelt? ___Y ___N

You were the: ____Driver, ____Front Seat Passenger, ____Rear Seat Passenger, ____Pedestrian

*Your car was impacted from: ___Front, ___Rear, ___Left, ___Right, ___Other

Did any part of your body strike any part of your vehicle? ___Y ___N. If yes, which one:_____

*Did airbags in your vehicle deploy? ___Y ___N ___My vehicle did not have airbags

*Were you knocked unconscious during the accident? ___Y ___N. If yes, how long? _____

*Did you go to the hospital (Emergency Department) following the accident? __Y __N

If yes, When? __Immediately ___ Later same day __Next day __Several days after the accident

How did you get to the hospital? __ Ambulance __ Private transportation

Name of hospital (Emergency Department):_____

Please select any of the following performed in the emergency department:

☐ x-ray ☐ CAT scan ☐ MRI ☐ None ☐ Other _____

Were medications prescribed from the emergency department? ___ Y ___ N,

if yes, which one?: _____

Were you released from the emergency department on the same day? ___ Y ___ N

if NO, how long did you stay in the hospital (ER)? _____

*Which medications have you been taking since the accident for pain? (please check all that apply):

☐ No Medications	☐ Pain Medications	☐ Codeine	☐ Flexeril (cyclobenzaprine)
☐ Over the Counter	☐ Muscle Relaxants	☐ Ibuprofen	
☐ Prescribed from the ER	☐ Tramadol	☐ Naproxen	
☐ NSAIDs	☐ Hydrocodone	☐ Robaxin (methocarbamol)	

☐ Other: _____

Did the above medications provide you with adequate pain relief? ___ Y; ___ N; ___ Partially.

*Have you seen any other physician, chiropractor, physical therapist for injuries from this accident? __Y __N

If yes, who and how soon after the accident? _____

Are you currently going to physical therapy? ___ Y ___N. **If yes**, how often: _____

Do you find physical therapy beneficial: ___ Y ___ N

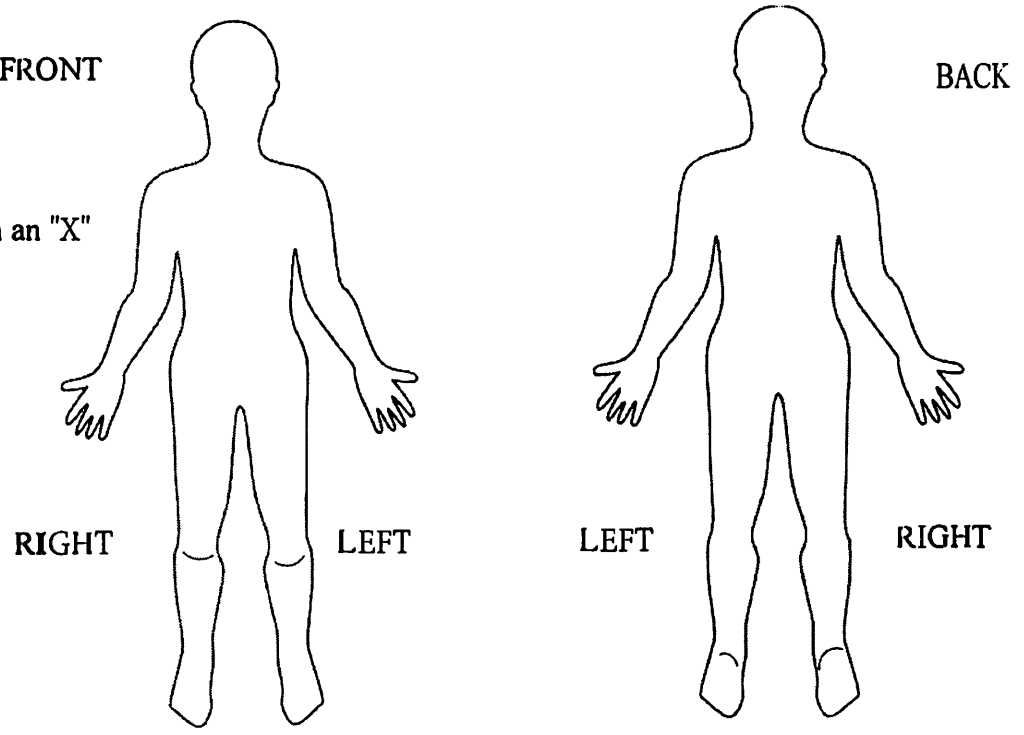
*Please indicate where the pain **has NOT improved**:

☐ Headache ☐ Elbow ☐ Lower Back ☐ Leg ☐ Other: _____

☐ Neck ☐ Arm ☐ Hip ☐ Foot/Ankle

☐ Shoulder ☐ Wrist/Hand ☐ Knee ☐ Mid/upper back

**Mark your area of pain with an "X"



On a scale of 0 to 10, please circle:

*Pain right now: 0 1 2 3 4 5 6 7 8 9 10

*Worst Pain throughout the day: 0 1 2 3 4 5 6 7 8 9 10

How often do you have this pain? ___Comes and goes ___Daily ___Constant ___Constant with periods of increased pain

Does it interfere with your: ___Work ___Sleep ___Daily routine ___Recreation

What **increases** the pain?

☐ Laying down ☐ Standing ☐ Bending ☐ Sneezing ☐ Bowel Movement ☐ Use of the Leg

☐ Sitting ☐ Walking ☐ Coughing ☐ Heavy Lifting ☐ Use of the Arm ☐ Other: _____

*Have you had prior accidents or injuries? __Y __N

If yes, when did it happen? _____ What happened? _____

_____

Please explain if you have had any remaining problems from the previous injury _____

_____

*Current medications (including over the counter medications):

Name

_____

_____

_____

*Medical history:

☐ NONE

☐ Osteoarthritis	☐ Headache	☐ HIV	☐ Seizure	☐ Arrhythmia	☐ Other Lung Disease
☐ RA	☐ Fibromyalgia	☐ Hepatitis B	☐ High blood pressure	☐ Pacemaker	☐ Thyroid
☐ Anxiety	☐ GI Bleeding	☐ Hepatitis C	☐ Coronary Artery Disease	☐ Emphysema	☐ Autoimmune
☐ Depression	☐ Heartburn/Reflux	☐ Diabetes	☐ Heart attack	☐ Asthma	☐ Cancer
☐ Migraine	☐ Stomach Ulcer	☐ Stroke	☐ CHF	☐ Blood Clots	☐ Bleeding

Other _____

*Allergy to medications (please also list reaction):

☐ No Known Drug Allergies

☐ Penicillin_____ ☐ Sulfa _____ ☐ Iodine / Contrast Dye _____

☐ Latex _____ ☐ Steroids _____ ☐ Local anesthetics (lidocaine, novocaine) _____

☐ Other _____

*Surgical History:

☐ NONE

☐ Appendectomy ☐ Tonsillectomy ☐ Cholecystectomy ☐ C-Section ☐ Hysterectomy ☐ Tubal Ligation

☐ Spinal cord stimulator ☐ Intrathecal pump ☐ Spine surgery____/____/____ (☐ Discectomy, ☐ Fusion, ☐ Laminectomy)

Other_____

*Family History (<u>please include parents and siblings only</u>):

☐ NONE

☐ Anxiety ☐ Drug Abuse ☐ Migraine ☐ Bleeding disorder ☐ Diabetes

☐ Depression ☐ Alcoholism ☐ Heart Disease ☐ Cancer

***Social History:**

Are you a: ☐ non-smoker ☐ former smoker ☐ current smoker

Do you drink alcohol?: ☐ Y ☐ N. <u>**If yes:**</u> ☐ socially ☐ daily

Are you currently employed? ☐ Y ☐ N. <u>**If yes,**</u> occupation: _____

Have you missed work due to pain after the accident? ☐ Y ☐ N. <u>**If yes,**</u> how many days have you missed in the last month due to pain? _____

Have your functional status and activities declined due to pain since the accident? ☐ Y ☐ N

REVIEW OF SYSTEMS (check all that apply)

GENERAL/CONSTITUTIONAL

NEGATIVE FOR ALL ☐ Fevers ☐ Night sweats ☐ Fatigue ☐ Weight gain
☐ Chills ☐ Sleep disturbance ☐ Weakness ☐ Weight loss

EYES

NEGATIVE FOR ALL ☐ Pain in both eyes ☐ Left Eye pain ☐ Blurred Vision
☐ Right Eye pain ☐ Decreased vision

CARDIOVASCULAR

☐ NEGATIVE FOR ALL ☐ Chest pain ☐ Dizziness ☐ Leg swelling
☐ Irregular heartbeat ☐ Weight gain ☐ Shortness of breath

RESPIRATORY

☐ NEGATIVE FOR ALL ☐ Cough ☐ Shortness of breath ☐ Sputum
☐ Wheezing ☐ Chest tightness ☐ Chest pain

GASTROINTESTINAL

☐ NEGATIVE FOR ALL ☐ Nausea ☐ Diarrhea ☐ Abdominal pain
☐ Vomiting ☐ Constipation ☐ Heart burn/Reflux

MUSCULOLOSKELETAL

NEGATIVE FOR ALL ☐ Carpal tunnel ☐ Leg cramps ☐ Muscle aches
☐ Sciatica ☐ Swollen joints ☐ Muscle weakness

NEUROLOGICAL

NEGATIVE FOR ALL ☐ Paralysis ☐ Tremor ☐ Dizziness
☐ Balance difficulty ☐ Poor coordination ☐ Gait abnormality
☐ Headache ☐ Irritability ☐ Seizures

ENDOCRINE

☐ NEGATIVE FOR ALL ☐ Difficulty sleeping ☐ Weight loss ☐ Cold intolerance
☐ Excessive thirst ☐ Frequent urination ☐ Sweating
☐ Weight gain / loss ☐ Heat intolerance ☐ Irregular menses

HEMATOLOGICAL/LYMPHATIC

☐ NEGATIVE FOR ALL ☐ Easy bruising ☐ Lymph nodes swelling

ALLERGIC

☐ NEGATIVE FOR ALL ☐ Seasonal allergy ☐ Rash ☐ HIV positive
☐ Hives ☐ Itching

PSYCHIATRIC

NEGATIVE FOR ALL ☐ Depressed mood ☐ Hallucinations ☐ Suicidal ideations
☐ Anxious mood ☐ Suicidal thoughts

ARE YOU TAKING ANTICOAGULANTS (BLOOD THINNERS)?

NO ☐ clopidogrel (Plavix) ☐ Enoxaparin (Lovenox) ☐ Rivaroxaban (Xarelto) ☐Dabigatran (pradaxa)
☐ warfarin (Coumadin) ☐ heparin ☐ cilostazol (Pletal) ☐ASA/Dipyridamol (Aggrenox)

☐ Other:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have (has) a change in health condition.

Signature patient/parent/guardian/or personal representative:_____
Date: ____/____/_____

VITAL SIGNS: HR_____, BP _____, WEIGHT _____ lb, HEIGHT _____ inches

Medical Assistant: _____

PEGASUS
PAIN MANAGEMENT

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

Reference: Texas administrative code, Title 22, part 9, chapter 170 (developed by the Texas pain Society, August 2007 www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician and/or his/her associates, technical assistants, nurses and other healthcare providers as he may deem necessary or advisable, to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the prescription(s) for dangerous and/or scheduled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. These tests include random unannounced checks for drugs and psychological evaluation if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. Presence of unauthorized substances may result in my discharge.

<u>For female patients only:</u>

- **To the best of my knowledge I am NOT pregnant.**
- **If I'm not pregnant, I will use appropriate contraception during my course of treatment. I promise, and it is MY responsibility, to inform my physician and/or his/her appropriately authorized assistant(s) immediately if I become pregnant.**
- **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.**
- **Besides the possible risks involved with the long-term use of medication(s), i.e. opioids/narcotic(s), I further understand that information on the effects of medication(s) on pregnant women and their unborn children is at present inadequate to guarantee that I and/or my unborn children may not experience significant or serious side effect(s).**
- **All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) to assure complete safety to my child. With full knowledge of this, I consent to its use and hold my physician and all staff harmless for injuries to the embryo/fetus/baby.**

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: Constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, orthostatic hypotension, arrhythmias, insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help regain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of all medication(s). I realize that the treatment for some will require prolonged or continuous use of medication(s) and that my condition will be evaluated on an individual basis.

I understand that I may withdraw from this treatment plan and discontinue the use of medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be afforded detoxification if needed under medical supervision.

I have been informed that the drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration (FDA) may not have been asked by the manufacturer to review for safety for effectiveness for my condition. Current medical literature shows that such "off label" use may be beneficial to some patients and I understand that recommended dosages for treating chronic pain are often exceeded in order to balance the benefit and risks to the patient.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of my condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medications (i.e. opioids, also called "narcotics, pain killers", and other prescription medications, etc.) for chronic pain prescribed by my physician and/or any appropriately authorize assistant(s). I understand that there are Federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) will only be provided so long as I adhere to the rules specified in this Agreement.

My physician and/or any appropriately authorized assistant(s) may at any time discontinue the medication(s) at his/her discretion. Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior.

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.
- I will use the medication(s) exactly as directed by my physician and/or he is appropriately authorized assistant(s).
- I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will not participate in the diversion of my medication; nor will I give or sell them to anyone else.
- All medication(s) must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician and/or his appropriately authorized assistant(s) to release my medical records to my pharmacist at his/her discretion.
- I understand that my medication(s) will be refilled on the regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they **MAY NOT BE REPLACED.**
- Refill(s) will not be ordered before the scheduled refill date. However, early refills are allowed when I'm traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even of my prescription(s) run out.
- I will receive medication(s) only from **ONE** physician and/or his appropriately authorized assistant(s) unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that

I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

- If it appears to my physician and/or he is appropriately authorized assistant(s) that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician and/or his appropriately authorized assistant(s) may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician or his appropriately authorized assistant(s) and/or a member of his staff liable for problems caused by the discontinuance of medication(s).
- I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s) treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy or/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.
- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician and/or he is appropriately authorized assistant(s) permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician and/or his appropriately authorized assistant(s). Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

I certify and agree to the following:

1. I'm not currently using illicit drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I'm reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have never been involved in the sale, illegal possession, diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
3. No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that I would otherwise continue to have chronic pain.
4. I have reviewed the side effects of the medication (s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication (s) in the treatment of my chronic pain.

Patient signature: _____ Date: _____

Physician signature (or authorized assistant): _____

Pegasus Pain Management, PLLC
MICHAEL ELLMAN, MD

PATIENT PERSONAL INFORMATION **Date: ____/____/____**

Primary Complaint _____ **Injury Date** ___/___/___

Work-related: Yes No **Auto Accident-related: Yes No** **Slip and Fall: Yes No**

Patient's Name:

_____
First MI Last

If Minor Patient, Guarantor's Name and:

_____
First MI Last

Email Address: _____ **May we contact you by email? Yes No**

Date of Birth: ____/____/____ **SS #:** ____-____-____ **Marital Status:** S M W D

Driver's License #: _____

Home Address:

_____
Street Apt # City State Zip Code

Cell Phone #: _____-_____-_____ **Home Phone #:** _____-_____-_____

Work Phone #: _____-_____-_____ *(Please circle which phone you prefer us to call)*

Employer:_____
Name Street City State Zip Code

Referring Physician:_____
Name City Phone #

Primary Care Physician:_____
Name City Phone #

PEGASUS
PAIN MANAGEMENT

Michael Ellman, MD
8604 Greenville Ave., Ste 103A, Dallas, TX 75243
P: (214) 702-5855 F: (877) 244-9193

Advanced Practice Nurse/Nurse Practitioner Consent

The physician(s) of Pegasus Pain Management want you to know that they employ Advanced Practice Nurse(s) (who are also called Nurse Practitioners) to assist them in a "team approach" to their high quality delivery of medical care.

An Advanced Practice Nurse (APN)/Nurse Practitioner (NP) is a registered nurse who has received advanced education and training in the provision of healthcare. Advanced Practice Nurses/Nurse Practitioners are not doctors. APN's/NP's of Pegasus Pain Management Can diagnose, treat, and monitor routine and complex pain disorders. If you are seen by an APN/NP, your doctor will review your care with the APN/NP as part of the care plan.

I have read the above and understands that in this practice a "team approach" is used, with my unique problems and/or needs presented and discussed with one or more physicians in the development of my care plan. I also understands that typically one M.D. will direct my overall care, but that from time to time I may be seen by any or all the practitioner's in this practice, including an Nurse Practitioner.

I hereby consent to the services of Nurse Practitioner for my healthcare needs.

I understand that I can refuse to see the Nurse Practitioner, and request to see a Physician. I understand that this may require my appointment to be re-scheduled.

Patient's signature: _____ Date: ____/____/____

ASSIGNMENT AND AUTHORIZATION

I authorize Michael Ellman, MD to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to Michael Ellman, MD. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges incurred with Michael Ellman, MD. A photocopy of this assignment is to be considered valid as the original.

Pegasus Pain Management
8604 Greenville Avenue, Suite 103A
Dallas, TX 75243
Office: 214-702-5855
Fax: 877-244-9193
E-mail: schedule@pegasuspain.com

I have read and understand the above paragraph.

Patient/Guardian Signature:_____

Date:_____

Witness Signature: _____

Date: _____

Ownership Disclosure

I understand that Pegasus Pain Management is a physician-owned medical practice. In addition to the services furnished by its physicians, Pegasus Pain Management offers a variety of ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services which operate under the following names: Ambulatory Surgical Institute of Dallas, Lakewood IOM LLC. ELK Neuro Monitoring PLLC., Fort Worth Source One LLC. I understand that my treating physician and/or other physician members of Pegasus Pain Management may have an ownership interest in or another type of financial relationship with one or more of these ancillary services.

During the course of my care, I may be referred to one or more of these ancillary services. I understand that I have the right to choose where to receive these services and that I may decline to receive my services through one of Pegasus Pain Management's affiliated entities. I also understand that where I choose to receive my ancillary services will have no effect on the medical care I receive through Pegasus Pain Management. Lastly, I have been given the opportunity to talk with my physician about his/her financial relationship with these entities.

I have read and understand the above paragraph.

Patient/Guardian Signature:_____

Date:_____

Witness Signature: _____

Date: _____

Patient and Financial Policy

8604 Greenville Ave., Ste. 103A
Dallas, TX 75243
Phone: 214.702.5855
Fax: 877.244.9193
pegasuspain.com

_____ I understand the insurance billing is a courtesy provided to me by Pegasus Pain Management and I assume full financial responsibility of any balance I incur.
Please Initial

_____ I understand co-pays, co-insurance, and deductibles are due at the time of my visits as well as any prior balance I may owe.
Please Initial

_____ It has been explained to me that should I decide to have procedures performed at Pegasus Pain Management my insurance company and I will receive two statements, one for the facility fees and one for the professional services rendered by the providers at Pegasus Pain Management.
Please Initial

_____ I assign benefits to be paid by my insurance company directly to the provider of services rendered to me. Furthermore, should the insurance company issue a check in my name I will notify Pegasus Pain Management immediately and arrange for payment of my balance. Should I cash any check issued by the Insurance company meant for reimbursement of services provided to me, I will assume full responsibility of the balance and will pay the balance within 30 days.
Please Initial

_____ I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity.
Please Initial

_____ I agree to pay all reasonable attorneys, collection, or returned check fees in the event of default of payment of my charges or balance arrangements.
Please Initial

_____ I understand that a $50.00 no show fee may be assessed for any appointment that I do not keep.
Please Initial

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms at its discretion.

PRINTED NAME OF PATIENT

_____

SIGNATURE OF PATIENT OR GURANTOR

_____ **DATE** _____

FINANCIAL POLICY & AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. In this Agreement, "Office" and "Clinic" shall refer to Michael Ellman, MD and/or Pegasus Pain Management, PLLC. I have reviewed the Office's Assignment form titled in short as "Assignment" or "Assignment / Lien." The terms and definitions contained in the Assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). Without limiting the foregoing, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office ("Term of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any of the foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan at the Office sole discretion. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges. Finally, I understand that the decision to bill payors is a contract between the office and myself, and will not be changed without the permission of the office.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges.

Additional Provisions. All office visits, x-rays, deductibles, and office visit co-payments are due and payable at the time of service excepting LOP accounts. Payment will be accepted in the form of cash, check, or major credit card. Outstanding balances that are not paid within 30 days may be subject to a monthly late fee of $5.00/month or 8% of the total due whichever is greater.

Patient requests for Medical Records and/or completion of forms will be charged as allowed by the state and will be completed within 14 business days of written request.

The patient understands that a 48 hour notice (during business hours) for all cancellations or scheduling changes is required. Failure of notification will result in a charge of $50 for all no show appointments. It is understand that exigent circumstances arise that may prevent the patient from providing said notice.
These events will be considered on a case by case basis.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print):

_____

Patient Signature:

_____

Date: _____/_____/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print):

_____

Parent/Guardian Signature:

_____

Date: _____/_____/_____

Pegasus Pain Management
8604 Greenville Avenue, Suite 103A
Dallas, TX 75243
Phone 214-702-5855
Fax 877-244-9193

HIPAA Privacy Practice

This notice describes how health information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.
If you have any questions about this notice, please contact Pegasus Pain Management at (214) 702-5855.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information.
For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.
To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated/ discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities.

- These activities generally include the following:
- To prevent or control disease, injury or disability.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.

• To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our facility
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing and must be contained on one page of paper legibly handwritten or typed in at least 10-point font size. In addition, you must provide a reason that supports your request for an amendment. **We may deny your request for an amendment if it is not in writing or does not include a reason to support the request In addition, we may deny your request if you ask us to amend information that:**

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information, which you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. To request this list of disclosures, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdrew or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about YOU for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request if from the front office staff

You may also obtain a copy of this notice at our Web site, **www.pegasuspain.com**. Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request.
If the first service delivery is delivered electronically, other than by telephone, we provide electronic notice in the same medium, automatically and contemporaneously in response to a first request for service.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Pegasus Pain Management. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

I have read and understand the above HIPAA Privacy Practice. If you choose, or are not able to sign, a staff member will sign their name, date.
THIS ACKNOWLEDGEMENT WILL BE PLACED IN YOUR RECORD

Print Patient Name	Signature of Patient/ Parent/ Legal Representative	Date

Pegasus Pain Management
8604 Greenville Avenue, Suite 103A, Dallas, TX 75243
Office: 214-702-5855 Fax: 877-244-9193

PERMISSION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTAITVE

IMPORTANT NOTE: The law prohibits release of confidential Medical information to any entity without the written, voluntary consent of the undersigned patient.

Name of Patient: _____

Date of Birth: _____

I give permission for Dr Michael Ellman or their designated representative to communicate information about my medical condition and treatment to:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

_____ _____
Signature of Patient Date

_____ _____
Signature of Representative Date

_____ _____
Printed Name of Representative Relationship

AUTHORIZATION OF CAUSE/S OF ACTION AND ASSIGNMENT

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Michael Ellman, MD and/or Pegasus Pain Management, PLLC; "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgement, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured or underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice, regardless of whether such Proceeds relate directly to my Charges or not; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony,) any Collection Costs incurred by the Office, interest, and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgement court costs, filing fees, service of process charges, attorney's fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Authorization of Cause of Action. I hereby assign and transfer to Michael Ellman, MD and/or Pegasus Pain Management, PLLC the cause of action that exists or may exist in my favor up to but not exceeding the amount of my medical bills, generated in my treatment, against such company/ies and/or party/ies and/or entity/ies and/or individual/s (the name(s) of which is/are believed to be or will be correctly set forth herein) that I or Michael Ellman, MD and/or Pegasus Pain Management, PLLC believe to be the responsible company/ies and/or party/ies and/or entity/ies and/or individual/s. This assignment and transfer includes any and all rights or claims I have from and/or against all sources, persons, or entities, including but not limited to liability insurance coverage, Personal Injury Protection, Medical Payments Coverage, Uninsured Motorist Coverage, and Underinsured Motorist Coverage. I further authorize Michael Ellman, MD and/or Pegasus Pain Management, PLLC to prosecute said action/s up to but not exceeding the amount of my medical bills either in my name or as Michael Ellman, MD and/or Pegasus Pain Management, PLLC as Michael Ellman, MD and/or Pegasus Pain Management, PLLC shall see fit. I also authorize Michael Ellman, MD and/or Pegasus Pain Management, PLLC to compromise, settle, or otherwise resolve said claim/s, for medical bills generated in my treatment, as Michael Ellman, MD and/or Pegasus Pain Management, PLLC shall see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/ies and/or other responsible party/ies and/or entity/ies and/or individual/s, Michael Ellman, MD and/or Pegasus Pain Management, PLLC will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amount Michael Ellman, MD and/or Pegasus Pain Management, PLLC does not collect from the insurance proceeds and/or other responsible party/ies and/or entity/ies and/or individual/s (whether it be all or part of what is due), I personally owe Michael Ellman, MD and/or Pegasus Pain Management, PLLC, up to but not to exceed the total amount of medical bills generated in my treatment and I agree to pay in a current manner.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the

amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent of those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the country where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

I have read, understood, and agree to the terms of this Assignment.

Patient Name (print):

_____

Patient Signature:

_____

Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):

_____

Parent/Guardian Signature:

_____

Date: ____/____/____

PEGASUS
PAIN MANAGEMENT
Michael Elman, MD

Request for Release of Medical Records

Date: _____

Patient Name: _____

Patient Date of Birth: _____

I hereby request and authorize the following provider to release medical records for the following patient.

Provider Name: _____

Address: _____

City, State, & Zip _____

Office Phone: _____ Fax: _____

Patient Signature: _____

Please release all medical records from (date)_____to Present.

PLEASE FORWARD RECORDS TO:

Pegasus Pain Management
8604 Greenville Ave 103A
Dallas, TX 75243
Phone: 214-702-9855
Fax : 877-244-9193